CalWORKs TREATMENT/SERVICES VERIFICATION

[To: **Central County GAIN Region IV**
3833 S. Vermont Ave
Los Angeles, CA. 90037] [From:]

[**FAX Number: (323) 731-9092**] [ ]

A. PROVIDER CERTIFICATION

As an authorized employee of the treatment/service provider agency named above, I certify that the individual named below is receiving: ☐ **DOMESTIC VIOLENCE (DV) CASE MANAGEMENT** ☐ **DOMESTIC VIOLENCE (DV) LEGAL SERVICES** ☐ **SUBSTANCE ABUSE SERVICES** ☐ **MENTAL HEALTH SERVICES** to help him/her overcome a barrier to employment. I understand that payment to contracted service provider is contingent on the CalWORKs participant maintaining eligibility to CalWORKs and complying with all requirements, assuming that the provider has been notified of the non-compliance by DPSS. In instances of substance abuse or mental health problems, this includes signing a Welfare-to-Work (WtW) plan which includes the appropriate treatment or services. For domestic violence victims, certain requirements can be waived, including a WtW plan. This form must be submitted within 10 workdays of client's signature, but not to exceed 30 days. In addition, the service provider must have received the GN 6008, Mental Health/Substance Abuse/Domestic Violence/Family Preservation Program Services Provider Progress Report, 90 days from service start date, to confirm participant's continued eligibility to CalWORKs.

Print Name/Title of Authorized Person	Date Signed	Phone Number	Fax Number

B. PARTICIPANT IDENTIFICATION

1. Name (first/last): _____
2. Social Security No. __ __ __ - __ __ - __ __ __ __ and/or DPSS Case No.: __ __ __ __ __ __ __
3. Participant began/will begin services: _____/_____/_____. Services are: ☐ Residential ☐ Non-Residential

C. SUBSTANCE ABUSE ☐ AND/OR MENTAL HEALTH ☐ (Complete when applicable)

4. ☐ Expected duration of needed treatment/services: _____ months.
5. ☐ Participant is receiving treatment/services 32 or more hrs/week. ☐ Yes ☐ No If no, number of hrs./week: _____
   (Participant may be considered full-time or may be eligible for a medical exemption and receive services as an exempt volunteer).
6. ☐ Participant is able to participate in other WtW activities? ☐ Yes ☐ No If yes, how many hrs/week: _____.
   (Participant may be eligible for an exemption and still participate in GAIN as an exempt volunteer).
7. ☐ Participant may be eligible to medical exemption. Please issue GN 6051, Verification of GAIN Exemption/Deferral, form*.
   * A medical exemption may be granted if a participant, due to a physical/mental disability, is unable to fully participate at least 30 days.
8. ☐ Participant is eligible for an exemption and will participate in GAIN as an exempt volunteer.

D. DOMESTIC VIOLENCE ☐ CASE MANAGEMENT AND/OR ☐ LEGAL SERVICES (Complete when applicable)

9. ☐ Expected duration of needed services: _____ months.
10. ☐ Participant is participating in DV services:_____ hrs./week and is able to do other WtW activities:_____ hrs/week **within** a WtW plan.
    To allow for successful participation, the following requirements shall be waived:
    - ☐ 32 hour/week GAIN participation requirement.
    - ☐ Core hours of participation.
    - ☐ Regular GAIN flow.
    - ☐ Mandatory participation in GAIN/WtW activities, which are subject to financial sanction.
    - ☐ Other, specify: _____ .
11. ☐ Participant shall be granted a DV Waiver from the mandatory WW activities and received DV services outside a WtW Plan.
12. ☐ Participant is participating in DV services: _____ hrs/week and other WtW activities:_____ hrs/week **outside** of a WtW plan.
    (Participant may be eligible for an exemption and still participate in GAIN as an exempt volunteer).

E. OTHER SUPPORTIVE SERVICE NEEDS (Complete when applicable)

Participant needs the following supportive services:

☐ Child care ☐ Public Transportation or ☐ Mileage: _____per month ☐ Other: _____

☐ Ancillary work/related expenses such as: ☐ Books ☐ Fees ☐ Uniforms, and/or ☐ Tools/Supplies

F. OTHER Recommended services ordered by the court system? ☐ DV Counseling ☐ Substance Abuse ☐ Mental Health

G. PARTICIPANT AUTHORIZATION

I authorize the Department of Public Social Services and the above treatment/services provider to verify information regarding the status of my CalWORKs application/case and/or continuing eligibility to receive CalWORKs Specialized Supportive Services. I am aware that my Mental Health and/or Substance Abuses services will be incorporated in my CalWORKs Welfare-to-Work Plan. I am aware that my Domestic Violence services may be incorporated now or eventually in my CalWORKs Welfare-to-Work Plan.

_____ _____
Participant's Signature Date

H. COUNTY ACTION: DATE:_____ ☐ ACCEPTED ☐ REJECTED ☐ PENDING ☐ CONDITIONAL ACCEPTANCE